Neoplasms of the Breast

2015-2016 FCDS EDUCATIONAL WEBCAST SERIES
STEVEN PEACE, BS, CTR
JANUARY 21, 2016

2016 Focus
- Anatomy
- SS 2000
- AJCC TNM
- MPH Rules

CDC & Florida DOH Attribution

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Presentation Outline

• Introduction to Neoplasms of the Breast
• Anatomy of the Breast
• Diagnostic Workup
• Critical Breast MPH Rules
• 2016 - New Use of “c” and “p” Prefix
• 2016 - New T, N, M Category Codes
• Anatomic Staging (AJCC TNM / SS2000)
• Text Documentation
• Staging Practice
• Questions

Presentation Outline

• What we will not be discussing today – not enuf time.
  • Risk Factors
  • Signs & Symptoms
  • Screening Guidelines
  • Details of Breast MPH Rules
  • Every Histologic Type of Breast Cancer
  • AJCC TNM General Instructions and Rules
  • Conflicts between MPH Rules and TNM Chapters
  • ER/PR or HER2 Site Specific Factor Coding
  • Biologic, Molecular, Single or Multi-Gene Testing
  • NCCN or Other Treatment Guidelines
Introduction

- Breast Cancer is not a single disease
- Breast Cancer has >21 histologic subtypes
- Breast Cancer has >4 molecular subtypes
- Two main breast cancer histologic types:
  - Lobular carcinoma starts in parts of the breast called lobules which produce milk.
  - Ductal carcinoma starts in the ducts that move milk from the lobules to the nipple.
- Most breast cancers are ductal type.
- Breast cancer can start in other areas of the breast (fatty, connective, or lymphatic tissues), but these occurrences are rare.

Lobular Carcinoma In Situ (LCIS)
Ductal Carcinoma In Situ (DCIS)
Invasive Lobular Carcinoma
Invasive Ductal Carcinoma
Mixed Ductal and Lobular Carcinoma
Mixed In situ and Invasive Cancers


Source: SEER Training Modules

Introduction

U.S. 2015 New Cases = 292,130
- 231,840 invasive cancers
- 60,290 in-situ cancers
  - 83% DCIS
  - 13% LCIS

U.S. 2015 Deaths = 40,290

| Table 1. Estimated New Female Breast Cancer Cases and Deaths by Age, US, 2015 |
|-----------------|-----------------|-----------------|
| Age             | In Situ Cases   | Invasive Cases  | Deaths          |
|                 |                 |                 |                 |
| <40             | 1,650           | 10,500          | 1,010           |
| 40-49           | 12,310          | 35,850          | 3,680           |
| 50-59           | 16,070          | 54,060          | 7,620           |
| 60-69           | 15,850          | 58,990          | 9,990           |
| 70-79           | 9,650           | 42,480          | 8,040           |
| 80+             | 3,860           | 28,960          | 10,860          |
| All ages        | 60,290          | 231,840         | 40,290          |


2015-2016 Breast Cancer Facts & Figures
Anatomy of the Breast

Source: SEER Training Modules

Source: http://cancer.org/breastcancer
Anatomy of the Breast

Clinical quadrants of the breast with the percentage of all cancers of the breast found in each.

Source: oncolink.org/resources

Anatomy of the Breast

Figure 6. Trends in Female Breast Cancer Incidence Rates* by Tumor Size, US, 1992-2012

*Rates are age-adjusted to the 2000 US Standard population and adjusted for reporting delay.
Source: SEER Registry, National Cancer Institute.
American Cancer Society, Inc., Surveillance Research, 2015
A blue dye in lumpectomy site
B axillary lymph nodes: levels I
C axillary lymph nodes: levels II
D axillary lymph nodes: levels III
E large lymphatic channels
F small lymphatic channels
G sentinel lymph nodes taking up dye

http://www.breastcancer.org
Lymphatics of the Breast

- **Isolated Tumor Cells (ITCs)** - very small deposits of tumor cells, no larger than 0.2 mm or no more than 200 cells, found in sentinel lymph node(s).
  - Presence of ITCs is NOT considered positive lymph node(s)
  - Usually identified using immunohistochemistry test on SLN
    - Cytokeratin Antigen Test or CK Test
    - Epithelial Membrane Antigen or EMA Test

- **Micrometastasis** - tumor deposits greater than 0.2mm but not greater than 2.0mm in largest dimension.

- **Macrometastasis** - resected lymph nodes greater than 2.0mm in largest dimension OR any clinically positive lymph nodes

- **Macrometastasis** – any nodal metastases detected by FNA or core biopsy regardless of the size of the tumor focus

Distant Metastasis

[Image of Distant Metastasis]

Tumor can be of any size

Multiple lymph node metastasis

Distant Metastasis

- Chest Wall
  - Ribs
  - Intercostal muscle
  - Serratus anterior muscle
  - Pectoral muscle is NOT chest wall invasion

- Lymph Nodes
  - Contralateral axillary lymph nodes
  - Contralateral internal mammary or
  - Supraclavicular lymph nodes
  - Cervical lymph nodes

- Distant Metastasis
  - Bone
  - Lung
  - Brain
  - Liver

- Disseminated tumor cells (DTCs) – Bone Marrow
- Circulating tumor cells (CTCs) – Blood Stream

Source: http://www.scripps.edu/felding/images/metastasis.jpg

Diagnostic Workup

- Mammography
- Other Breast Imaging
- Confirmation of Disease
  - Core Biopsy or FNA of primary tumor
  - Excisional Biopsy of primary tumor
  - Lumpectomy or Mastectomy
- Lymph Node Assessment
  - Core Biopsy or FNA of Lymph Node
  - Sentinel Lymph Node Biopsy
  - Sentinel Lymph Node Removal
  - Axillary Node Dissection
- ER/PR/HER2
- 21-Gene Recurrence Score Assay (Oncotype DX)
- Metastatic Workup as Indicated
Breast Imaging - Screening vs. Diagnostic

• **Screening** – looking for cancer before a person has any symptoms to find cancer at early/treatable stage

• **Risks of Screening** – False Negative, False Positive, Radiation Exposure, Anxiety, Pain, Discomfort, Screening may not alter patient outcomes (survival and/or mortality)

• **Diagnostic** – patient already had one or more screening procedure(s) or has obvious clinical evidence of cancer (palpable tumor mass or palpable nodes) and is now being seen to confirm the diagnosis using image-guided FNA, stereotactic core biopsy, tissue biopsy, excisional biopsy, etc.

Understanding Results of Breast Imaging

• **Breast Imaging Reporting and Database System (BI-RADS)**

  - BI-RADS® serves as a classification system for mammography, ultrasound, and magnetic resonance imaging (MRI) of the breast.

  - BI-RADS® serves as a comprehensive guide providing standardized breast imaging terminology, report organization and assessment structure by category

  - BI-RADS® is a quality assurance guide designed to standardize breast imaging reporting and facilitate outcome monitoring.

Source: American College of Radiology (ACR)
Understanding Results of Breast Imaging

TABLE 4: BI-RAD classification of mammographic lesions

<table>
<thead>
<tr>
<th>BI-RAD class</th>
<th>Description</th>
<th>Probability of malignancy (%)</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Needs additional evaluation</td>
<td></td>
<td>Diagnostic mammogram, ultrasonographic image</td>
</tr>
<tr>
<td>1</td>
<td>Normal mammogram</td>
<td>0</td>
<td>Yearly screening</td>
</tr>
<tr>
<td>2</td>
<td>Benign lesion</td>
<td>0</td>
<td>Yearly screening</td>
</tr>
<tr>
<td>3</td>
<td>Probably benign lesion</td>
<td>&lt; 2</td>
<td>Short interval followup</td>
</tr>
<tr>
<td>4*</td>
<td>Suspicious for malignancy</td>
<td>20</td>
<td>Biopsy</td>
</tr>
<tr>
<td>5</td>
<td>Highly suspicious for malignancy</td>
<td>90</td>
<td>Biopsy</td>
</tr>
<tr>
<td>6</td>
<td>Biopsy-proven malignancy</td>
<td>100</td>
<td>Treatment</td>
</tr>
</tbody>
</table>

BI-RAD = Breast Imaging Reporting Data System

* The ACR recommends that each site be divided into three subcategories: 4A, low suspicion; 4B, intermediate suspicion; and 4C, moderate concern but not classic for malignancy.

Source: American College of Radiology (ACR)

Critical Breast MPH Rules

- Stay Tuned
- 2017 Updates
- Text Only Rules
- New MPH Database
MP Rules - Abbreviated

Unknown number
• M1. Unknown if single or multiple tumors = single

One tumor
• M2. Inflammatory carcinoma = single
• M3. A single tumor = single

Multiple Tumors
• M4. Different topography = multiple
• M5. Diagnosis dates > 5 years apart = multiple
• M6. Inflammatory carcinoma = single
• M7. Tumors on both sides = multiple
• M8. Invasive after in situ > 60 days = multiple
• M9. (Intra)ductal and Paget disease = single
• M10. Lobular and (intra)ductal = single
• M11. Multiple intraductal and/or ductal = single
• M12. Histology different = multiple
• M13. All other = single

Source: AFritz and Associates, LLC
Breast Cancer Histology

- **Adenocarcinoma, NOS (8140/3)**
  - Not a preferred term for breast cancer
  - Sometimes this is all the pathologist can characterize
- **Ductal or Duct Carcinoma (850_/2 or 850_/3)**
  - 80% of all invasive breast cancers
  - 85% of all non-invasive breast cancers
  - Numerous Subtypes (Table 1 & Table 2 - MPH Rules)
- **Papillary Subtype (8503 NOT 8050)**
- **Lobular Carcinoma (852_/2 or 852_/3)**
  - 10% of all invasive breast cancers
  - 15% of all non-invasive breast cancers
- **Other Breast Cancers – 10%**
  - Mucinous or colloid (848_/3) – 3-5%
  - Inflammatory (8530/3) – 1-3%
  - Paget Disease (8540/3) – 1%
  - Phyllodes Tumor (9020/) – 1%
  - Medullary (851_/3) – 1%
  - Tubular (8211/3) – 1%
- **Ductular Carcinoma (8521/3) is NOT ductal carcinoma**
- **Many Mixed Histologies Have Special Codes – Use Them**
- **Many Mixed Histologies Have Special Rules – Use Them**
Inflammatory Carcinoma of Breast

- Combined Clinical and Pathological Diagnosis
  - Clinical
    - Symptoms resembling breast inflammation
    - Resembles acute mastitis of breast
    - Diffuse involvement of breast
    - Nipple retraction common
    - No primary tumor mass
    - Warm and reddened
    - Firm and swollen
    - Peau d’orange
    - Itching
  - Pathological
    - Dermal lymphatic invasion proven on biopsy
    - Assign histology code 8530/3 only when final dx on path states ICB
    - Record dermal lymphatic invasion in stage [CS TS, CS Ext, “T” (TNM)]

Paget’s Disease of the Nipple

- AJCC TNM 8th ed. Statements about Paget’s Disease
- ICD-O-3 Rules
- MPH Rules
- AJCC Instruction

Resolution: It Depends on the evidence for each case
Mixed In-Situ CA and Invasive CA

**ONLY CODE THE CHARACTERISTICS OF THE INVASIVE CARCINOMA**

**IGNORE ALL IN-SITU COMPONENTS**

**DO NOT CODE COMBINATION HISTOLOGY**

**REPEAT**

CODE HISTOLOGY BASED ONLY ON THE INVASIVE CANCER CHARACTERISTICS

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Table 3—Combination Codes for Breast Cancer:

Use this two-page table with rules H5, H9, H17, H18, H19, H24, H25, H26 and H28 to select combination histology codes. Compare the terms in the diagnosis to the terms in Columns 1 and 2. If the terms match, code the case using the ICD-O-3 histology code in column 4. Use the combination codes listed in this table only when the histologies in the tumor match the histologies listed below.

<table>
<thead>
<tr>
<th>Column 1: Required Histology</th>
<th>Column 2: Combined with Histology</th>
<th>Column 3: Combination Term</th>
<th>Column 4: Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lobular and duct histologies from Tables 1 and 2</td>
<td>Lobular carcinoma in situ</td>
<td>Infiltrating duct and lobular carcinomas in situ</td>
<td>8322/2</td>
</tr>
<tr>
<td>Infiltrating duct and</td>
<td>Infiltrating lobular carcinoma</td>
<td>Infiltrating duct and lobular carcinomas</td>
<td>8322/2</td>
</tr>
<tr>
<td>Infiltrating duct and one or more of the histologies in Column 2 OR two or more of the histologies in Column 2</td>
<td>Solid</td>
<td>Infiltrating duct and other types of carcinomas</td>
<td>8355/3</td>
</tr>
<tr>
<td>Infiltrating duct and one or more of the histologies in Column 2</td>
<td>Apocrine</td>
<td>Infiltrating duct and other types of carcinomas</td>
<td>8355/3</td>
</tr>
<tr>
<td>Infiltrating duct and one or more of the histologies in Column 2</td>
<td>Microcystic</td>
<td>Infiltrating duct and other types of carcinomas</td>
<td>8355/3</td>
</tr>
<tr>
<td>Infiltrating duct and one or more of the histologies in Column 2</td>
<td>Membranous</td>
<td>Infiltrating duct and other types of carcinomas</td>
<td>8355/3</td>
</tr>
<tr>
<td>Infiltrating duct and one or more of the histologies in Column 2</td>
<td>Solid</td>
<td>Infiltrating duct and other types of carcinomas</td>
<td>8355/3</td>
</tr>
<tr>
<td>Infiltrating duct and one or more of the histologies in Column 2</td>
<td>Apocrine</td>
<td>Infiltrating duct and other types of carcinomas</td>
<td>8355/3</td>
</tr>
<tr>
<td>Infiltrating duct and one or more of the histologies in Column 2</td>
<td>Membranous</td>
<td>Infiltrating duct and other types of carcinomas</td>
<td>8355/3</td>
</tr>
</tbody>
</table>

Table 3 continues on the next page.
### Combination Codes

**Breast Equivalent Terms: Definitions, Tables and Illustrations**  
C506-C508  
(Excludes lymphoma and leukemia M599-9989 and Kaposi sarcoma M491.0)

<table>
<thead>
<tr>
<th>Column 1:</th>
<th>Column 2: Combined with Histology</th>
<th>Column 3: Combination Term</th>
<th>Column 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infiltrating lobular carcinoma and</td>
<td>Tubular</td>
<td>Infiltrating lobular mixed with other types of carcinomas</td>
<td>E54 3</td>
</tr>
<tr>
<td>Adeno lobular</td>
<td></td>
<td>Note: invasive carcinomas only. Do not use this code for in situ</td>
<td></td>
</tr>
<tr>
<td>Medullary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paget disease (NOS and macro)</td>
<td>Paget disease and infiltrating duct carcinomas</td>
<td>E541 3</td>
<td></td>
</tr>
<tr>
<td>Paget disease and</td>
<td>Paget disease and infiltrating duct carcinomas</td>
<td>E541 3</td>
<td></td>
</tr>
<tr>
<td>Infiltrating duct carcinoma (includes any specific histologic type listed in Table 2)</td>
<td>Paget disease and infiltrating duct carcinomas</td>
<td>E541 3</td>
<td></td>
</tr>
<tr>
<td>Infiltrating duct carcinoma (includes any specific histologic type listed in Table 2)</td>
<td>Paget disease and infiltrating duct carcinomas</td>
<td>E541 3</td>
<td></td>
</tr>
</tbody>
</table>

*Newly used for breast cancer*

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### Breast Cancer Staging

**American Joint Committee on Cancer**

**High clinical stage**

- Level 1: Axillary contents, internal mammary
- Level 2: Internal mammary, supravcicular, clavicular

**Axillary node levels**

- Level 1: Axillary contents
- Level 2: Internal mammary, supravcicular, clavicular

**Supravacicular region**

- Level 1: Axillary contents
- Level 2: Internal mammary, supravcicular, clavicular

**Lymph nodes in the breast**

- Level 1: In situ carcinoma
- Level 2: Stage 0

**Histological confirmation**

- Level 1: In situ carcinoma
- Level 2: Stage 0

**Primary tumor size**

- Level 1: ≤ 2 mm or cluster of fewer than 200 cells
- Level 2: >2 mm or cluster of 200 or more cells
SEER Summary Stage

Purpose of Staging
- Biochemical Tumor Markers
- Molecular Tumor Markers
- Genetic Mutations/Variations
- Risk Stratification

Breast Cancer Stage Distribution

Source: SEER Summary Staging Manual 2000

http://ww5.komen.org/images
“c” and “p” and “yp”

Clinical (c)

Clinical Stage is determined before any type of definitive therapy is started and is used as a guide to determine what the first steps used to establish the diagnosis of breast cancer should be and to decide upon approach and intent of 1st treatment – should 1st treatment include lumpectomy, SLN, mastectomy, neoadjuvant chemo, or palliative care.

Clinical Stage – includes physical exam with inspection and palpation of the skin, breast, and lymph nodes (axillary, supraclavicular, and cervical), breast imaging and other imaging studies, and pathologic examination of the breast or other tissue(s) used to establish/confirm the diagnosis.

Pathologic (p)

Pathologic Stage is assigned following complete resection of the primary tumor and must include microscopic examination of the primary, regional lymph nodes and/or other suspect tissues.

Pathologic Stage is used to guide anatomic stage specific adjuvant therapy decisions and to estimate prognosis.

Pathologic Stage includes all information in the clinical setting PLUS all information obtained from surgical reports and pathology reports related to the extent of cancer spread through the completion of definitive surgery performed as a part of the 1st course of treatment or within 4 months of initial diagnosis of cancer in the absence of disease progression.
“c” and “p” and “yp”

- Post Neoadjuvant Treatment (yp)

- Post Neoadjuvant Treatment Stage is assigned following a prescribed “course” of neoadjuvant therapy (chemo, biologics, radiation, etc.).

- Post Neoadjuvant Treatment Stage includes microscopic examination of the primary, regional lymph nodes and/or other suspect tissues.

- Response to Neoadjuvant Therapy is determined by comparison of pre-treatment Clinical Stage to post-treatment Pathologic Stage and is qualified by the presence or absence of cancer in the primary tumor, regional lymph nodes, etc. or T, N, or M Category Differences.
  - Pathologically Confirmed Complete Response (CR)
  - Pathologically Confirmed Partial Response (PR)
  - Pathologically Confirmed No Response (NRL)

2016 Prefix Requirements / Physician Stage

- 2016 Requirements for “c” and “p” prefix use
  - Now must include “c” or “p” prefix for each T, N, M Category
  - New Codes for T, N, and M will be available in software soon
  - Use of Allowable Codes will be Strictly Enforced in 2016
  - Clinical Stage now includes cT, pTis, cN and either c or pM
  - Pathologic Stage now includes pT, pN and either c or pM
  - Convert Roman Numerals (I, II, III) to Arabic (1, 2, 3)

- Physician Stage can be difficult to qualify as it may be a mixed clinical and pathologic stage, especially when the AJCC Stage is provided per history. Always check the Physician Stage to validate use of prefix and the correct T, N, and M Category Codes that best reflect the case.
AJCC Self Instruction - Updates

AJCC T, N, and M Category Options for Registry Data Items in 2016

Diana M. Gross, RHIT, CTR

https://cancerstaging.org/CSE/Registrar/Pages/AJCC-Curriculum.aspx

AJCC Self Instruction - Updates

In Situ Neoplasm

- CIS definition
  - Has not involved any structures in primary organ that
  - Allows tumor cells to spread to regional nodes or distant sites

- CIS exception to stage group guidelines
  - Clinical stage
    - pTis cN0 cM0 clinical stage 0
  - Pathologic stage
    - pTis cN0 cM0 pathologic stage 0

- Caution for pathologic stage
  - Cannot use CIS rule in isolation
  - Must also meet pathologic stage resection criteria
  - Avoids sampling error when resection might show invasion
  - Example: TURB

https://cancerstaging.org/CSE/Registrar/Pages/AJCC-Curriculum.aspx
### 2016 New Category Code Format - EXAMPLE

#### Table 1. TNM Clin T [940]

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>c1B</td>
<td>cT1b</td>
</tr>
<tr>
<td>c1B1</td>
<td>cT1b1</td>
</tr>
<tr>
<td>c1B2</td>
<td>cT1b2</td>
</tr>
<tr>
<td>c1C</td>
<td>cT1c</td>
</tr>
<tr>
<td>c1D</td>
<td>cT1d</td>
</tr>
<tr>
<td>c2</td>
<td>cT2</td>
</tr>
<tr>
<td>c2A</td>
<td>cT2a</td>
</tr>
<tr>
<td>c2A1</td>
<td>cT2a1</td>
</tr>
<tr>
<td>c2A2</td>
<td>cT2a2</td>
</tr>
<tr>
<td>c2B</td>
<td>cT2b</td>
</tr>
<tr>
<td>c2C</td>
<td>cT2c</td>
</tr>
<tr>
<td>c2D</td>
<td>cT2d</td>
</tr>
</tbody>
</table>

**Deleted codes:** A [Ta], IS [Tis], ISP [Tisp], ISPd [Tispd]

**Added codes:** pA [PTa], pIS [PTis], pISU [PTisu], pISD [PTisd]

---

### AJCC Self Instruction - Updates

**Explaining Blanks and X, Ambiguous Terminology and Support for AJCC Staging**

Donna M. Gress, RHIT, CTR

[https://cancerstaging.org/CSE/Registrar/Pages/AJCC-Curriculum.aspx](https://cancerstaging.org/CSE/Registrar/Pages/AJCC-Curriculum.aspx)
**T Category – tumor size and extension**

- **Non-Invasive or In Situ** – not always measurable
- **Microinvasive Neoplasm** – less than 1mm in size
- **Mixed Non-Invasive (In Situ) and Invasive** - RULE
- **Invasive Only** – Tumor Size is Measured
- **The Primary Tumor Extends Beyond Breast Tissue**

**Non-Invasive/Minimally Invasive/Invasive**

- **Non-Invasive Includes:**
  - Ductal Carcinoma In Situ (DCIS)
  - Lobular Carcinoma In Situ (LCIS)
  - Paget’s Disease of Nipple with No Associated In Situ or Invasive Cancer (ductal or lobular)

- **Minimally Invasive Includes:**
  - Tumor is = or < 1mm in Greatest Dimension

- **Invasive Includes:**
  - Infiltrating Duct Carcinoma (IDC)
  - Infiltrating Lobular Carcinoma (ILC)
  - Invasive Plus Non-Invasive Cancer in Same Breast
  - Paget’s Disease of Nipple with Invasive or In Situ Cancer
  - Other Invasive Neoplasm and Inflammatory Carcinoma
Tumor Size and “T” in TNM

Primary Tumor Extension and “T” in TNM
### “T” Codes and Description

**Clinical and Pathologic “T” Codes and Description - Identical**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>Primary tumor cannot be assessed</td>
</tr>
<tr>
<td>Tis</td>
<td>No evidence of primary tumor</td>
</tr>
<tr>
<td>T1a</td>
<td>Carcinoma in situ</td>
</tr>
<tr>
<td>T1b</td>
<td>Ductal carcinoma in situ</td>
</tr>
<tr>
<td>T1c</td>
<td>Lobular carcinoma in situ</td>
</tr>
<tr>
<td>T1d</td>
<td>Paget’s disease of the nipple NOT associated with invasive carcinoma and/or carcinoma in situ (CCS) or (CCS) is the underlying breast parenchyma. Carcinomas in the breast parenchyma associated with Paget’s disease are categorized based on the size and characteristics of the parenchymal disease, although the presence of Paget’s disease should still be noted.</td>
</tr>
<tr>
<td>T2</td>
<td>Tumor &gt;20 mm but ≤50 mm in greatest dimension</td>
</tr>
<tr>
<td>T3</td>
<td>Tumor &gt;50 mm in greatest dimension</td>
</tr>
<tr>
<td>T4</td>
<td>Tumor of any size with direct extension to the chest wall and/or to the skin (abscess or skin nodules). Note: Invasion of the dermis alone does not qualify as T4</td>
</tr>
</tbody>
</table>

### 2016 Valid Codes for “T” Category

**Table 1. TNM Clin T [940]**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>blank</td>
<td>Not recorded</td>
</tr>
<tr>
<td>cX</td>
<td>cTX</td>
</tr>
<tr>
<td>cT0</td>
<td>cT0</td>
</tr>
<tr>
<td>pTA</td>
<td>pTA</td>
</tr>
<tr>
<td>pTSU</td>
<td>pTSp</td>
</tr>
<tr>
<td>pTSD</td>
<td>pTSpd</td>
</tr>
</tbody>
</table>

- **Deleted codes:** A [Ta], IS [Tis], ISP [Tisp], ISP [Tispd]
- **Added codes:** pA [pTa], pTS [pTis], pTSU [pTisu], pTSD [pTisd]

**NAACCR 2016 Implementation Guidelines (NAACCRv16)**
2016 Valid Codes for “T” Category

### Table 2. TNM Path T [880]

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Code</th>
<th>Definition</th>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(blank)</td>
<td>Not recorded</td>
<td>p1B</td>
<td>pT1B</td>
<td>p1D</td>
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<td>p1D1</td>
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<td>pT1B2</td>
<td>p1D2</td>
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<td>p1E</td>
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<td>p1A1</td>
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</tr>
</tbody>
</table>

Added codes: pISU [pTisu], pISD [pTisd]
N Category - Regional Lymph Nodes

Lymphatics of the Breast

- **Isolated Tumor Cells (ITCs)** - very small deposits of tumor cells, no larger than 0.2 mm or no more than 200 cells, found in sentinel lymph node(s).
  - Presence of ITCs is NOT considered positive lymph node(s)
  - Usually identified using immunohistochemistry test on SLN
    - Cytokeratin Antigen Test or CK Test
    - Epithelial Membrane Antigen or EMA Test

- **Micrometastasis** - tumor deposits greater than 0.2mm but not greater than 2.0mm in largest dimension.

- **Macrometastasis** - resected lymph nodes greater than 2.0mm in largest dimension OR any clinically positive lymph nodes

- **Macrometastasis** – any nodal metastases detected by FNA or core biopsy regardless of the size of the tumor focus
Breast Lymph Nodes and “N” in TNM

ACS and AJCC Breast Cancer Staging Poster

“N” Codes and Description

Regional Lymph Nodes (N)

N0: No regional lymph node metastases
N1: Metastases to axillary lymph node(s)
N2: Metastases to axillary lymph node(s) and ipsilateral internal mammary nodes
N2a: Metastases to axillary lymph node(s)
N2b: Metastases to ipsilateral internal mammary nodes
N3: Metastases to contralateral internal mammary nodes
N3a: Metastases to contralateral internal mammary nodes
N3b: Metastases to contralateral internal mammary lymph node(s)
N3c: Metastases to contralateral internal mammary node(s) and ipsilateral internal mammary nodes

Note: Clinically detected is defined as detected by imaging studies (excluding lymphoscintigraphy) or by clinical examination and having characteristics highly suspicious for malignancy or a presumed pathologic macrometastasis based on fine needle aspiration.

Notes:

- Clinically detected is defined as detected by imaging studies (excluding lymphoscintigraphy) or by clinical examination and having characteristics highly suspicious for malignancy or a presumed pathologic macrometastasis based on fine needle aspiration.
“N” Codes and Description

Pathologic (pN)

- Micrometastases; or metastases in 1–3 auxiliary lymph nodes; or in intracranial (level III auxiliary) lymph nodes, or in clinically detected*** bilateral internal mammary lymph nodes in the presence of one or more positive level I, II auxiliary lymph nodes; or in more than three auxiliary lymph nodes and in internal mammary lymph nodes with micrometastases or macrometastases detected by sentinel lymph node biopsy but not clinically detected*** or in ipsilateral supraclavicular lymph nodes.

- pN1a: Metastases in 1–3 auxiliary lymph nodes, at least one tumor deposit greater than 2.0 mm or micrometastases or macrometastases detected by sentinel lymph node biopsy but not clinically detected.

- pN1b: Metastases in internal mammary nodes with micrometastases or macrometastases detected by sentinel lymph node biopsy but not clinically detected.

- pN1c: Metastases in 1–3 auxiliary lymph nodes and in internal mammary lymph nodes with micrometastases or macrometastases detected by sentinel lymph node biopsy but not clinically detected.

- pN1d: Metastases in 4–9 auxiliary lymph nodes, or in clinically detected*** internal mammary lymph nodes in the absence of auxiliary lymph node metastases.

- pN2a: Metastases in 4–9 auxiliary lymph nodes, at least one tumor deposit greater than 2.0 mm.

- pN2b: Metastases in clinically detected*** internal mammary lymph nodes in the absence of auxiliary lymph node metastases.

- pN3a: Metastases in 10 or more auxiliary lymph nodes.

- pN3b: Metastases in clinically detected*** bilateral internal mammary lymph nodes.

- pN3c: Metastases in clinically detected*** ipsilateral internal mammary lymph nodes.

- pN3d: Metastases in clinically detected*** bilateral internal mammary lymph nodes.

- pN3e: Metastases in ipsilateral supraclavicular lymph nodes.

*** "Not clinically detected" is defined as not detected by imaging studies (excluding lymphoscintigraphy) or not detected by clinical examination.

**** "Clinically detected" is defined as detected by imaging studies (excluding lymphoscintigraphy) or by clinical examination and having characteristics highly suspicious for malignancy or a presumed pathologic macrometastasis based on fine needle aspiration biopsy or cytologic examination.

* Classification is based on axillary lymph node dissection with or without sentinel lymph node biopsy. Classification is solely on sentinel lymph node biopsy without subsequent axillary lymph node dissection designated (p) for "sentinel node,” for example, p(N)X(p).

** RT-PCR: reverse transcriptase-polymerase chain reaction.
2016 Valid Codes for “N” Category

Table 3. TNM Cln N [950]

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Code</th>
<th>Definition</th>
<th>Code</th>
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NAACCR 2016 Implementation Guidelines (NAACCRv16)
2016 Valid Codes for “N” Category

Table 4. TNM Path N [890]

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<tr>
<th>Code</th>
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<td>pN0b</td>
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<tr>
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</table>

Added code: c0 [cN0]

NAACCR 2016 Implementation Guidelines (NAACCRv16)

M Category - Metastasis

Stage IV Cancer

Tumor can be of any size
Multiple lymph node metastasis

“M” Codes and Description

Distant Metastasis (M)

M0  No clinical or radiographic evidence of distant metastases

cM0(F) No clinical or radiographic evidence of distant metastases, but deposits of molecularly or microscopically detected tumor cells in circulating blood, bone marrow, or other nonregional nodal tissue that are no larger than 0.2 mm in a patient without symptoms or signs of metastases

M1  Distant detectable metastases as determined by classic clinical and radiographic means and/or histologically proven larger than 0.2 mm

2016 Valid Codes for “M” Category

NAACCR 2016 Implementation Guidelines (NAACCRv16)
Anatomic Stage/Prognostic Group

NOTE: No Biologic or Molecular SSF Results Change the Stage Group

<table>
<thead>
<tr>
<th>ANATOMIC STAGE/PROGNOSTIC GROUPS</th>
<th>Stage I</th>
<th>Stage IA</th>
<th>Stage IIA</th>
<th>Stage IIB</th>
<th>Stage IIIA</th>
<th>Stage IIIB</th>
<th>Stage IV</th>
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<td>T0</td>
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</tr>
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</table>

Text Documentation

Source: NCRA Informational Abstracts – Improving Text
Case 1 – Case Vignette

- **HISTORY:** 62 year old Asian female admitted for biopsy of 1cm abnormality noted on mammography. No mass felt in the left breast, left axilla WNL.
- **CT CHEST:** no abnormalities noted
- **MAMMOGRAPHY:** 1cm abnormality in left UOQ, possible malignancy. Recommend biopsy.
- **PATHOLOGY Excision:** Left UOQ Breast biopsy – low grade DCIS (solid, cribriform and papillary subtypes) 6mm area of involvement. ER/PR pos, HER2 not stated
- **PATHOLOGY Wide Excision and SNL Biopsy:** No residual carcinoma. 1 sentinel lymph nodes negative for carcinoma 0/1. IHC stain for Cytokeratin is negative.
Case 1 – Answer & Rationale

Practice Case #1

**C50.4 – Left Breast, Upper Outer Quadrant**

**B523/21 – Low Grade Intraductal Carcinoma with Mixed Subtypes (Non-invasive)**

<table>
<thead>
<tr>
<th>Clinical TNM AICC Stage Group</th>
<th>pT1c pN0 cM0</th>
<th>c0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathologic TNM AICC Stage Group</td>
<td>pT1c pN0(N1) cM0</td>
<td>c0</td>
</tr>
<tr>
<td>SEER Summary Stage 2000</td>
<td>0</td>
<td>In Situ</td>
</tr>
</tbody>
</table>

Clinical Stage for an in-situ neoplasm without ANY area(s) of invasion OR ANY area(s) of micropenetration. Tis (and T1mi) can ONLY be diagnosed microscopically. You cannot assign a clinical Tis. But, you can use pTis for in-situ only.

NO and MO based on 2 factors, non-invasive only and physical exam negative in axilla (in-situ neoplasm may not get even a SRL biopsy). NOTE: Neither blank or X is valid because of stage of disease (in situ) and workup can include but does not require imaging or physical exam. If neither physical exam nor imaging was performed then N still should be assigned NO due to Tis. IMX not allowed

MO based on negative CT chest and abdomen

Clinical Stage pTis pN0 cM0 // Path Stage Group 0

Case 2 – Case Vignette

- **HISTORY:** 65 year old black female admitted for biopsy and resection of 2cm mass noted on mammography. Palpable mass in UOQ right breast, right axilla WNL.
- **CT CHEST:** no abnormalities noted
- **MAMMOGRAPHY:** 2cm stellate mass in right UOQ, suspicious for malignancy. Recommend biopsy.
- **PATHOLOGY** Excision: Right UOQ Breast biopsy – infiltrating duct carcinoma, 1.6cm in greatest dimension, Nottingham Grade 2. ER/PR - , HER2 +
- **PATHOLOGY** Wide Excision and SNL Biopsy: No residual carcinoma. 2 sentinel lymph nodes negative for carcinoma 0/2. IHC stain for Cytokeratin is positive.
Case 2 – Answer & Rationale

Practice Case #2
C50.4 – Infiltrating Duct Carcinoma, Nottingham Grade 2 = Grade 2 per 2014 Grade Coding Instructions

<table>
<thead>
<tr>
<th>Clinical TNM Staging</th>
<th>pT1c N0 M0</th>
<th>cIA</th>
<th>Clinical Tumor Size = 2cm from imaging = cT1c. Clinical Nodes = none noted on physical exam = cN0. Clinical Mets = none. CT chest = cM0. MX not allowed. Clinical Stage = cT1c cN0 cM0 // Clinical Stage Group IA.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathologic TNM Staging</td>
<td>pT1c pN0(+) M0</td>
<td>cIA</td>
<td>Pathologic staging is based on histologic review of resection of primary site and regional lymph nodes specimen. Pathologic Tumor size = 1.5 cm = pT1c. Pathologic Lymph Nodes noted only with positive IHC (Cytokeratin Stain) for Isolated Tumor Cells or ITCs = pN0(+) in resection specimen. ITC + lymph nodes are still counted as NO. DO NOT COUNT ITCs as + LN. No pathologic confirmation of any metastasis – so, you take the clinical M0. Pathologic Stage pT1c pN0(+) cM0 // Path Stage Grp IA.</td>
</tr>
<tr>
<td>SEER Summary Stage 2000</td>
<td>1 localized</td>
<td>Localized</td>
<td></td>
</tr>
</tbody>
</table>

Case 3 – Case Vignette

- HISTORY: 57 year-old Hispanic female with 2.5cm mass at 10:00 in right breast and prominent axillary node noted on screening mammography and on PE.
- CT CHEST: few small (<1cm) nonspecific hilar lymph nodes noted in chest. Exam otherwise negative.
- PROCEDURE: Lumpectomy, right breast with core biopsy of sentinel axillary lymph nodes (2) – Level I
- PATHOLOGY: Moderately differentiated infiltrating duct carcinoma with extensive associated DCIS, high nuclear grade; cribriform, papillary and solid types. Invasive component 1.5cm in greatest linear dimension, Nottingham Grade 2 (3+2+1=6), core biopsies (3) of suspected axillary lymph node showing tumor present in all core fragments (3/3).
Case 3 – Answer & Rationale

<table>
<thead>
<tr>
<th>Practice Case #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>C50.4 – Right Breast, Upper Outer Quadrant (10:00 position)</td>
</tr>
<tr>
<td>1200/32 – Infiltrating Duct Carcinoma</td>
</tr>
</tbody>
</table>

**Clinical TNM**
**AKCC Stage Group**
- cT2 cN1 cM0
- cT2 cN1 cM0

**Pathologic TNM**
**AKCC Stage Group**
- pT1c pN1a cM0
- pT1c pN1a cM0

**SEER Summary**
**Stage 2000**
- 2 Regional Lymph Nodes Only

- **Clinical Tumor Size** = 3.2cm from imaging and physical exam = cT2.
- **Clinical Nodes** = prominent axillary node is clinically positive lymph node warranting core needle biopsy to rule out mets = cN1.
- **Clinical Mets** = nonspecific <1cm hilar nodes are not positive = cM0. MX not allowed, MX based on CT chest.
- **Clinical Stage** = cT2 cN1a cM0 // Clinical Stage Group IIb.

- **Pathologic Tumor Size** = 1.3cm (invasive component only).
- **Pathologic Lymph Nodes** = N1a (you can still code N2b even though a complete axillary node dissection was not performed because the node was prominent (clinically positive) then proven to be metastatic with 3 core biopsies of the lymph node. Not ITCs or Micromets - so is Macromets for LN noted.
- **Pathologic Stage** = pT1c pN1a cM0 // Path Stage Group IIA.

**Rationale**

**Case 4 – Case Vignette**

- **HISTORY:** 61 yr old white female, lifelong smoker, with multiple medical problems including recent suspicious result on routine screening mammography. PE negative.
- **CT CHEST:** Negative
- **STEREOTACTIC NEEDLE BIOPSY UIQ LEFT BREAST:** Infiltrating duct carcinoma, Nottingham Grade 1. DCIS, low grade (less than 0.1cm focus)
- **SIMPLE MASTECTOMY:** Infiltrating duct carcinoma, Nottingham Grade 2 (1.3cm) arising from an encapsulated (intracystic) papillary carcinoma, 0.9 x 0.7cm, DCIS, intermediate grade (1.0 x 0.7cm), solid type. All margins negative. Hormone receptor and immunohistochemical stains ordered and results will be reported in supplemental report.
Case 4 – Answer & Rationale

<table>
<thead>
<tr>
<th>Clinical TNM</th>
<th>Pathologic TNM</th>
<th>SEER Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>AJCC Stage Group</td>
<td>pT1c cN0 cM0</td>
<td>Stage 2000</td>
</tr>
<tr>
<td>cTX cN0 cM0</td>
<td>pT1c cN0 cM0</td>
<td>Localized</td>
</tr>
<tr>
<td>c99</td>
<td>0/4</td>
<td>Localized</td>
</tr>
</tbody>
</table>

No Clinical Tumor Size is noted on mammogram or physical exam. cTX because there was imaging and physical exam performed but cannot be assessed because report not available (not cTXblank).

N based on no mention of suspicious or prominent lymph nodes in axilla on physical exam or imaging. M0 not allowed. MO based on CT chest.

Clinical Stage cTX cN0 cM0 // Clinical Stage Group - 99

Pathologic staging is based on histologic review of resection of primary site and regional lymph nodes specimen.

Pathologic Tumor Size = 1.3cm,
Pathologic Lymph Nodes = cN0 (you can use the clinical N0 when T1 or T2 tumor size - not clear in instructions but is allowed and valid. Otherwise, this case would be unstaged when it is really just a stage 1 cancer. No pathologic confirmation of any metastasis - so, you take the clinical M0.

Pathologic Stage pT1c cN0 cM0 // Path Stage Group IA

Case 5 – Case Vignette

- HISTORY: 57 year old obese white female with hard left subareolar solid mass noted by patient and confirmed on imaging. Mass measures 3 x 4 x 2cm. PE shows no enlarged lymph nodes in left axilla but one prominent supraclavicular node is noted on physical examination.
- FNA Left Breast Mass: adenocarcinoma
- Left Modified Mastectomy: Left Breast with a 5cm area of intraductal carcinoma (solid, cribriform and papillary subtypes) surrounding a 3.8cm area of invasive ductal carcinoma noted. 4 of 6 Level I nodes +, 1/8 Level II nodes +, Supraclavicular node - core bx – positive.
- ER/PR negative, HER2 negative (triple negative)
Case 5 – Answer & Rationale

**Case 5 – Answer & Rationale**

<table>
<thead>
<tr>
<th>Practice Case #5</th>
<th>C501 – Left Breast, Subareolar = Central Breast (NOT LOWER BREAST – COMMON ERROR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT CHEST</td>
<td>Negative</td>
</tr>
<tr>
<td>BONE SCAN</td>
<td>Abnormal uptake L4-L5 concerning for metastatic disease</td>
</tr>
<tr>
<td>PLAIN FILM XRAY</td>
<td>L-SPINE: osseous mets L4-L5</td>
</tr>
<tr>
<td>FNA BREAST MASS</td>
<td>adenocarcinoma</td>
</tr>
<tr>
<td>RIGHT MODIFIED RADICAL MASTECTOMY</td>
<td>poorly differentiated infiltrating duct carcinoma. Tumor extends to pectoralis muscle and deep margin with involvement of dermal lymphatics. 10/15 axillary lymph nodes involved with largest node measuring 2.8cm in size.</td>
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<tr>
<td>Biopsy L4</td>
<td>metastatic adenocarcinoma c/w breast primary</td>
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<td>ER/PR +, HER2</td>
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<tr>
<td>Patient refused pre-operative therapy – mastectomy only</td>
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</table>
### Case 6 – Answer & Rationale

#### Practice Case #6

**CSO 1 – Right Breast, Central**

<table>
<thead>
<tr>
<th>Case Group</th>
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<th>Pathologic Stage</th>
<th>SEER Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>cT4d cN1 cM2</td>
<td>Clinical Tumor Size based on physical exam and patient history with inflammatory carcinoma clinically and dermal lymphatic involvement proven. N based on physical exam with multiple suspicious large nodes in axilla. M1 is based on bone scan and follow-up plain film confirmation of L4-L5 involvement. Clinical Stage cT4d cN1 cM2 // Clinical Stage Group IV</td>
<td>pT4d pN3e pM1</td>
<td>Distant Bone Mets</td>
</tr>
</tbody>
</table>

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### Questions

- Bone Mets: